


MATERNAL AND CHILD HEALTH BRANCH
APPLICATION FOR CERTIFICATION AS A COMPREHENSIVE PERINATAL SERVICES PROGRAM (CPSP) PROVIDER
For Official Use Only

Local Agency Control Number _____ Date Received _____

State Control Number _____ Date Received _____

Please read all the attached materials thoroughly before completing this form and retain a copy for your records. Please type or print in black ink. When completed, the original application form should be mailed with one copy to your local Comprehensive Perinatal Services Program Coordinator.

1. Name of Applicant (Name must be the same name used for current Medi-Cal provider number.)				Telephone Number ()	
Other Name (if any used for provider services)				Telephone Number ()	
Service Address (number/street)			Billing Address (number/street)		
City	State	ZIP Code	City	State	ZIP Code
Contact Person		Telephone Number ()	Contact Person		Telephone Number ()

2. **Please check provider type which applies to this application. The CPSP provider must be a:**

<input type="checkbox"/> General practice physician	<input type="checkbox"/> Family practice physician	<input type="checkbox"/> Family nurse practitioner	<input type="checkbox"/> Obstetrician/gynecologist
<input type="checkbox"/> Pediatric nurse practitioner	<input type="checkbox"/> Pediatrician	<input type="checkbox"/> Preferred provider organization	<input type="checkbox"/> Clinic
<input type="checkbox"/> Hospital	<input type="checkbox"/> Alternative birthing center	<input type="checkbox"/> Certified nurse midwife	<input type="checkbox"/> Group (any one of whose members is general or family practice, OB/GYN, or pediatrician)

3. Are you a current Medi-Cal provider? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, do not complete the rest of this form. Contact your local CPSP coordinator.	Current Medi-Cal provider number for application*
--	---

* Current Medi-Cal provider number to be used by the applicant at the service address. Separate applications must be completed for each site that has a separate Medi-Cal provider number. If you are applying as an alternative birthing center, please contact your local CPSP coordinator for special instructions.

[illegible]

DHS 4448 (12/99) Page 3 of 4

5. Please indicate to what extent the applicant or staff have received state-approved training in the provision of the Comprehensive Perinatal Services Program:

Staff person(s): _____ Date: _____ Location of training: _____

If you have not yet participated in such training, indicate whom and when you **intend** to: _____

6. Please attach and label the following requested documents in the order they are described:

- I **Prenatal Medical Record form(s):** Attach a blank sample prenatal medical records form(s).
- II **Individualized Care Plan:** Includes obstetric, nutrition, psychosocial, and health education components.
- III **Nutrition, Psychosocial, and Health Education Assessment Tools:** Nutrition, psychosocial, and health education documents for initial assessment, trimester, reassessments, and postpartum assessments.
- IV **General Description of Practice:** A description as to how the practice, clinic, and/or organization will provide CPSP services for the obstetric, nutrition, psychosocial, and health education components.
- V **Delivery Hospitals:** The name(s) and address(es) of the hospital(s) at which deliveries are planned to take place.
- VI **Referral Services:** The names and addresses of the persons and agencies to whom you will refer for OB and non-OB care; well-child pediatric care (e.g., CHDP); family planning services, Supplemental Nutrition Program for Women, Infants, and Children (WIC) services; genetic services; and dental services.
- VII **Antepartum/Intrapartum/Postpartum Agreements:** If a person or entity other than the applicant will be responsible for performing and for billing, antepartum and/or intrapartum and/or postpartum obstetrical care, the applicant must attach a written agreement(s) to this application. The agreement(s) must describe the relationship and specific responsibilities of the applicant and the obstetric care provider(s), including the flow of patient services and patient information between all providers. It should include, as well, the name(s) of the delivery hospital(s) where obstetric provider has privileges, how emergency services will be provided, and billing responsibilities.

7. Please give approximate number of total deliveries _____ and Medi-Cal deliveries _____ by the applicant for the last 12 months.

Please furnish any other information that you feel would help evaluate your application to become approved as a Comprehensive Perinatal Service Program provider in the Department of Health Services' Medi-Cal program.

I certify under penalty of perjury that the above information is true, accurate, and complete to the best of my knowledge. I understand that incorrect or inaccurate information may affect my eligibility to receive Medi-Cal reimbursement and that I must report changes to the above information to the local CPSP coordinator.

Authorized agent's name (please print or type)

Title (please print or type)

➤ _____
Authorized agent's original signature

Date

All information submitted with this application will be part of a file that is open for public inspection pursuant to the California Public Records Act, Government Code, Section 6250 ET SEQ.

FOR OFFICIAL USE ONLY

Actions taken on application:

- | | | |
|--|---------|-------|
| <input type="checkbox"/> Returned for additional information | _____ | _____ |
| | Initial | Date |
| <input type="checkbox"/> Application resubmitted | _____ | _____ |
| | Initial | Date |
| <input type="checkbox"/> Returned for additional information | _____ | _____ |
| | Initial | Date |
| <input type="checkbox"/> Application resubmitted | _____ | _____ |
| | Initial | Date |

Recommended disposition to DHS:

- ☐ To approve ☐ Not to approve

Signature: ➤ _____ Date: _____

Title: _____

Local agency: _____

- ☐ Attach Local Agency Review Checklist (CPP 3)